General Assembly

Raised Bill No. 1023

January Session, 2015

LCO No. **4022**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING REVISIONS TO THE HEALTH INSURANCE STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (a) of section 38a-183 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) A health care center governed by sections 38a-175 to 38a-192, inclusive, shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a full schedule of the amounts to be paid by the subscribers and has obtained the commissioner's approval thereof. Such filing shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the contract or policy. The commissioner may refuse such approval if **[**he**]** the commissioner finds such amounts to be excessive, inadequate or discriminatory. As used in this subsection, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

(2) Premium rates offered to individuals shall be consistent with the requirements set forth in section 38a-481, as amended by this act.

(3) Premium rates offered to small employers, as defined in section 38a-564, as amended by this act, shall be consistent with the requirements set forth in section 38a-567, as amended by this act.

(4) **[**Each**]** No such health care center shall **[**not**]** enter into any agreement with subscribers unless and until it has filed with the commissioner a copy of such agreement or agreements, including all riders and endorsements thereon, and until the commissioner's approval thereof has been obtained. The commissioner shall, within a reasonable time after the filing of any request for an approval of the amounts to be paid, any agreement or any form, notify the health care center of **[**either his**]** the commissioner's approval or disapproval thereof.

Sec. 2. Section 38a-199 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) A hospital service corporation is defined as a non-profit-sharing corporation without capital stock organized under the laws of the state for the purpose of establishing, maintaining and operating a plan whereby comprehensive health care, **[**which shall include**]** that includes inpatient and outpatient hospital care and home care, provided and billed by an approved general, special or chronic disease hospital, an approved clinic or an approved chronic and convalescent nursing home, and services incidental thereto, may be provided, at the expense of said corporation, to subscribers to such plan under a contract entitling such subscribers to the benefits provided therein. When so determined by any such corporation comprehensive health care shall also include appliances, drugs, medicines, supplies and all other health goods and services, including the services of physicians, doctors of dentistry and other licensed practitioners of the healing arts. Each such corporation shall be governed by sections 38a-199 to 38a-

209, inclusive, and shall, except as **[**specifically designated herein**]** otherwise provided in this title, be exempt from the provisions of the general statutes relating to insurance. The provisions of sections 38a-815 to 38a-819, inclusive, except subdivision (9) of section 38a-816, shall be applicable to such corporation. Such hospitals, clinics and chronic and convalescent nursing homes as shall be contained in a list of approved institutions maintained by the Department of Public Health shall be deemed approved for the purposes of sections 38a-199 to 38a-209, inclusive.

(b) A hospital service corporation providing health care benefits to plan subscribers under the provisions of subsection (a) of this section may, upon obtaining the approval of the Insurance Commissioner as provided in section 38a-208, as amended by this act: (1) **[**Adjust the rates to be paid by any group or groups of its subscribers based upon past and prospective loss experience and may classify subscribers and groups of subscribers and determine rates with reference to standards for variations or risks or expenses which it may establish; (2) contract**]** Contract for the coordination of benefits with other hospital service corporations, medical service corporations or insurance companies to avoid duplication of benefits to be provided to its group subscribers; **[**(3)**]** (2) make loans, grants or provide anything of value to a health care center covering all or part of the cost of health services provided to members; **[**(4)**]** (3) contract with a health care center to provide insurance or similar protection to cover the cost of care provided through health care centers and to provide coverage in the event of the insolvency of the health care center; and **[**(5)**]** (4) establish, maintain, own and operate health care centers as a line of business, provided that (A) aggregate investments hereafter made by such corporation shall not exceed ten per cent of such corporation's contingency reserve as of the date of the investment; (B) such investments shall not be repaid or recovered from rates charged by such corporation for its non-health-care-center lines of business; and (C) the commissioner **[**shall find**]** finds, based upon evidence furnished by such corporation, that the

financial condition of such corporation and the rates of its non-health-care-center subscribers are not unduly jeopardized by such investment. **[**Subdivisions (1) and (2)**]** Subdivision (2) of this subsection shall be subject to such regulations as may be adopted by the Insurance Commissioner, in accordance with the provisions of chapter 54, to establish **[**guidelines of eligibility for experience rating and adoption of**]** coordination of benefits clauses in health care contracts.

(c) Each hospital service corporation shall maintain reserves equal in amount to its liabilities under all its policy contracts, as the same are computed in accordance with regulations **[**of the commissioner**]** adopted in accordance with chapter 54 upon reasonable consideration of ascertained experience for the purpose of adequately protecting the subscriber and securing the solvency of such company. Each such corporation shall maintain a reserve for contingencies **[**which**]** that shall not be less than the amount required by companies licensed to transact accident and health insurance, under section 38a-72. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, prescribing the maximum amount that may be held in the reserve for contingencies, and in adopting such regulations, **[**he**]** shall consider the stability, solvency and interests of the corporation and the interests of the subscribers and other affected persons. **[**The commissioner shall allow a reasonable period of time for compliance with this section, not to exceed five years.**]** On and after October 1, 1974, the commissioner may require a hospital service corporation to adjust its reserve for contingencies to comply with the provisions of this section and to adjust its rates or benefits or both to reflect the adjustment in the reserve for contingencies.

Sec. 3. Section 38a-208 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No such corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a full schedule of the rates to be paid by the subscribers

and has obtained said commissioner's approval thereof. Such filing shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the contract. The commissioner may refuse such approval if **[**he**]** the commissioner finds such rates to be excessive, inadequate or discriminatory. As used in this subsection, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

(b) Premium rates offered to individuals shall be consistent with the requirements set forth in section 38a-481, as amended by this act.

(c) Premium rates offered to small employers, as defined in section 38a-564, as amended by this act, shall be consistent with the requirements set forth in section 38a-567, as amended by this act.

(d) No hospital service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a copy of such contract, including all riders and endorsements thereof, and until said commissioner's approval thereof has been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation **[**either of his**]** of the commissioner's approval or disapproval thereof.

Sec. 4. Section 38a-214 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) A nonprofit medical service corporation is defined as a non-profit-sharing corporation without capital stock organized under the laws of the state for the purpose of establishing, maintaining and operating a plan whereby comprehensive health care, **[**which shall include**]** that includes inpatient and outpatient hospital care and home care, provided and billed by an approved general, special or chronic disease hospital, an approved clinic or an approved chronic and

convalescent nursing home and services incidental thereto may be provided, at the expense of said corporation, to subscribers to such plan under a contract entitling such subscribers to the benefits provided therein. When so determined by any such corporation, comprehensive health care shall also include appliances, drugs, medicines, supplies and all other health goods and services, including the services of physicians, doctors of dentistry and other licensed practitioners of the healing arts. Any such corporation **[**which**]** that provides coverage for the services of physicians shall also provide coverage for the services of chiropractors licensed under chapter 372 and naturopaths licensed under chapter 373. Each such corporation shall, except as **[**specifically designated herein**]** otherwise provided in this title, be exempt from the provisions of the general statutes relating to insurance. The provisions of sections 38a-815 to 38a-819, inclusive, except subdivision (9) of section 38a-816, shall be applicable to such corporation. Such hospitals, clinics and chronic and convalescent nursing homes as shall be contained in a list of approved institutions maintained by the Department of Public Health shall be deemed approved for the purposes of sections 38a-214 to 38a-225, inclusive.

(b) A medical service corporation providing health care benefits to plan subscribers under the provisions of subsection (a) of this section may, upon obtaining the approval of the Insurance Commissioner as provided in section 38a-218, as amended by this act: (1) **[**Adjust the rates to be paid by any group or groups of its subscribers based upon past and prospective loss experience and may classify subscribers and groups of subscribers and determine rates with reference to standards for variations of risks or expenses which it may establish; (2) contract**]** Contract for the coordination of benefits with other hospital service corporations, medical service corporations or insurance companies to avoid duplication of benefits to be provided to its group subscribers; **[**(3)**]** (2) make loans, grants or provide anything of value to a health care center covering all or part of the cost of health services provided to members; **[**(4)**]** (3) contract with a health care center to provide

insurance or similar protection to cover the cost of care provided through health care centers and to provide coverage in the event of the insolvency of the health care center; and **[**(5)**]** (4) establish, maintain, own and operate health care centers as a line of business, provided that (A) aggregate investments hereafter made by such corporation shall not exceed ten per cent of such corporation's contingency reserve as of the date of the investment; (B) such investments shall not be repaid or recovered from rates charged by such corporation for its non-health-care-center lines of business; and (C) the commissioner **[**shall find**]** finds, based upon evidence furnished by such corporation, that the financial condition of such corporation and the rates of its non-health-care-center subscribers are not unduly jeopardized by such investment. **[**Subdivisions (1) and**]** Subdivision (2) of this subsection shall be subject to such regulations as may be adopted by the Insurance Commissioner, in accordance with the provisions of chapter 54, to establish **[**guidelines of eligibility for experience rating and adoption of**]** coordination of benefits clauses in health care benefit contracts.

(c) Each medical service corporation shall maintain reserves equal in amount to its liabilities under all its policy contracts, as the same are computed in accordance with regulations **[**of the commissioner**]** adopted in accordance with chapter 54 upon reasonable consideration of ascertained experience for the purpose of adequately protecting the subscriber or securing the solvency of such company. Each such corporation shall maintain a reserve for contingencies **[**which**]** that shall not be less than the amount required by companies licensed to transact accident and health insurance, under section 38a-72. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, prescribing the maximum amount that may be held in the reserve for contingencies, and in adopting such regulations, **[**he**]** shall consider the stability, solvency and interests of the corporation, and the interests of the subscribers and other affected persons. **[**The commissioner shall allow a reasonable period of time for

compliance with this section, not to exceed five years.**]** On and after October 1, 1974, the commissioner may require a medical service corporation to adjust its reserve for contingencies to comply with the provisions of this section and to adjust its rates or benefits or both to reflect such adjustment in the reserve for contingencies.

Sec. 5. Section 38a-218 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No such medical service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a full schedule of the rates to be paid by the subscriber and has obtained said commissioner's approval thereof. Such filing shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the contract. The commissioner may refuse such approval if **[**he**]** the commissioner finds such rates are excessive, inadequate or discriminatory. As used in this subsection, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

(b) Premium rates offered to individuals shall be consistent with the requirements set forth in section 38a-481, as amended by this act.

(c) Premium rates offered to small employers, as defined in section 38a-564, as amended by this act, shall be consistent with the requirements set forth in section 38a-567, as amended by this act.

(d) No such medical service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a copy of such contract, including all riders and endorsements thereof, and until said commissioner's approval thereof has been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation **[**either of his**]** of the commissioner's approval or

disapproval thereof.

Sec. 6. Section 38a-481 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No individual health insurance policy shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the commissioner. Rate filings shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the policy. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to establish a procedure for reviewing such policies. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions **[**which**]** that are unfair or deceptive or **[**which**]** that encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer **[**which**]** that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders. As used in this subsection, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

(b) No rate filed under the provisions of subsection (a) of this section shall be effective until it has been **[**filed and**]** approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate **[**within

thirty days after it has been filed**]** if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.

(c) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity **[**which**]** that delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate.

(d) **[**For the purposes of this section, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.**]** No individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state shall include any provision that reduces payments on the basis that an individual is eligible for Medicare by reason of age, disability or end-stage renal disease, unless such individual enrolls in Medicare. If such individual enrolls in Medicare, any such reduction shall be only to the extent such coverage is provided by Medicare.

(e) Nothing in this chapter shall preclude the issuance of an individual health insurance policy that includes an optional life insurance rider, provided the optional life insurance rider shall be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

[(f) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity that delivers, issues for delivery, amends, renews or continues

an individual health insurance policy in this state shall: (1) Move an insured individual from a standard underwriting classification to a substandard underwriting classification after the policy is issued; (2) increase premium rates due to the claim experience or health status of an individual who is insured under the policy, except that the entity may increase premium rates for all individuals in an underwriting classification due to the claim experience or health status of the underwriting classification as a whole; or (3) use an individual's history of taking a prescription drug for anxiety for six months or less as a factor in its underwriting unless such history arises directly from a medical diagnosis of an underlying condition.**]**

(f) Health insurance issued to an association or other insurance arrangement that is not made up solely of employer groups shall be treated as individual health insurance.

(g) (1) As used in this subsection, "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder, and "grandfathered plan" has the same meaning as "grandfathered health plan" as provided in the Affordable Care Act.

(2) Each individual health insurance policy subject to the Affordable Care Act shall be offered on a guaranteed issue basis with respect to all eligible individuals or dependents.

(3) With respect to grandfathered plans of a policy under subdivision (2) of this subsection, the premium rates charged or offered shall be established on the basis of a single pool of all grandfathered plans.

(4) With respect to nongrandfathered plans of a policy under subdivision (2) of this subsection:

(A) The premium rates charged or offered shall be established on the basis of a single pool of all nongrandfathered plans, adjusted to

reflect one or more of the following classifications:

(i) Age, in accordance with a uniform age rating curve established by the commissioner;

(ii) Geographic area, as defined by the commissioner;

(iii) Tobacco use, except that such rate may not vary by a ratio of greater than 1.5 to 1.0 and may only be applied with respect to individuals who may legally use tobacco under state and federal law. For purposes of this subparagraph, "tobacco use" means the use of tobacco products four or more times per week on average within a period not longer than the six months immediately preceding. "Tobacco use" does not include the religious or ceremonial use of tobacco;

(B) Total premium rates for family coverage shall be determined by adding the premiums for each individual family member, except that with respect to family members under twenty-one years of age, the premiums for only the three oldest covered children shall be taken into account in determining the total premium rate for such family.

(5) Premium rates for a grandfathered or nongrandfathered policy under subdivision (2) of this subsection may vary by (A) actuarially justified differences in plan design, and (B) actuarially justified amounts to reflect the policy's provider network and administrative expense differences that can be reasonably allocated to such policy.

Sec. 7. Subsections (a) and (b) of section 38a-513 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) No group health insurance policy, as defined by the commissioner, or certificate shall be **[**issued or**]** delivered or issued for delivery in this state unless a copy of the form for such policy or certificate has been submitted to and approved by the commissioner

under the regulations adopted pursuant to this section. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, concerning the provisions, submission and approval of such policies and certificates and establishing a procedure for reviewing such policies and certificates. **[**If the commissioner issues an order disapproving the use of such form, the**]** The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions that are unfair or deceptive or that encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such order.

(2) No group health insurance policy or certificate for a small employer, as defined in section 38a-564, as amended by this act, shall be delivered or issued for delivery in this state unless the premium rates have been submitted to and approved by the commissioner. Premium rate filings shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the policy. As used in this subdivision, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity **[**which**]** that delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate.

Sec. 8. Section 38a-476 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) **[**(1)**]** For the purposes of this section: **[**, "health insurance plan"**]** (1) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract. **[**and**]** "Health insurance plan" does not include (A) short-term health insurance issued on a nonrenewable basis with a duration of six months or less, accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided that the carrier offering such policies files on or before March first of each year a certification with the Insurance Commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after October 1, 1993, the carrier files with the commissioner the information and statement required in this subparagraph at least thirty days prior to the date such policy is issued or delivered in this state.

(2) "Insurance arrangement" means any "multiple employer welfare arrangement", as defined in Section 3 of the Employee Retirement Income Security Act of 1974, as amended from time to time, except for any such arrangement **[**which**]** that is fully insured within the meaning

of Section 514(b)(6) of said act, as amended from time to time.

(3) "Preexisting conditions provision" means a policy provision **[**which**]** that limits or excludes benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, for which any medical advice, diagnosis, care or treatment was recommended or received before such effective date. Routine follow-up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment for purposes of this section unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information. Pregnancy shall not be considered a preexisting condition.

[(4) "Qualifying coverage" means (A) any group health insurance plan, insurance arrangement or self-insured plan, (B) Medicare or Medicaid, or (C) an individual health insurance plan that provides benefits which are actuarially equivalent to or exceeding the benefits provided under the small employer health care plan, as defined in subdivision (12) of section 38a-564, whether issued in this state or any other state.**]**

[(5)**]** (4) "Applicable waiting period" means the period of time imposed by the group policyholder or contractholder before an individual is eligible for participating in the group policy or contract.

(b) (1) No group health insurance plan or insurance arrangement shall impose a preexisting conditions provision **[**that excludes coverage for (A) individuals eighteen years of age and younger, or (B) a period beyond twelve months following the insured's effective date of coverage. Any preexisting conditions provision shall only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during

the six months immediately preceding the effective date of coverage**]** on any individual.

(2) No individual health insurance plan or insurance arrangement shall impose a preexisting conditions provision **[**that excludes coverage for (A) individuals eighteen years of age and younger, or (B) a period beyond twelve months following the insured's effective date of coverage. Any preexisting conditions provision shall only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage**]** on any individual.

(3) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center shall refuse to issue an individual health insurance plan or insurance arrangement to **[**individuals eighteen years of age and younger**]** any individual solely on the basis that **[**an**]** such individual has a preexisting condition.

[(c) All health insurance plans and insurance arrangements shall provide coverage, under the terms and conditions of their policies or contracts, for the preexisting conditions of any newly insured individual who was previously covered for such preexisting condition under the terms of the individual's preceding qualifying coverage, provided the preceding coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, except in the case of a newly insured group member whose previous coverage was terminated due to an involuntary loss of employment, the preceding coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided such newly insured group member or dependent applies for such succeeding coverage within thirty days of the member's or dependent's initial

eligibility.

(d) With respect to a newly insured individual who was previously covered under qualifying coverage, but who was not covered under such qualifying coverage for a preexisting condition, as defined under the new health insurance plan or arrangement, such plan or arrangement shall credit the time such individual was previously covered by qualifying coverage to the exclusion period of the preexisting condition provision, provided the preceding coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan, except in the case of a newly insured group member whose preceding coverage was terminated due to an involuntary loss of employment, the preceding coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided such newly insured group member or dependent applies for such succeeding coverage within thirty days of the member's or dependent's initial eligibility.

(e) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center which issues in this state group health insurance subject to Section 2701 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, shall comply with the provisions of said section with respect to such group health insurance, except that the longer period of days specified in subsections (c) and (d) of this section shall apply to the extent excepted from preemption in Section 2723(B)(2)(iii) of said Public Health Service Act.

(f) The provisions of this section shall apply to every health insurance plan or insurance arrangement issued, renewed or continued in this state on or after October 1, 1993. For purposes of this section, the date a plan or arrangement is continued shall be the

anniversary date of the issuance of the plan or arrangement. The provisions of subsection (e) of this section shall apply on and after the dates specified in Sections 2747 and 2792 of the Public Health Service Act as set forth in HIPAA.**]**

[(g)**]** (c) (1) Notwithstanding the provisions of subsection (a) of this section, a short-term health insurance policy issued on a nonrenewable basis for six months or less **[**which**]** that imposes a preexisting conditions provision shall be subject to the following conditions: **[**(1)**]** (A) No such preexisting conditions provision shall exclude coverage beyond twelve months following the insured's effective date of coverage; **[**(2)**]** (B) such preexisting conditions provision may only relate to conditions, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received during the twenty-four months immediately preceding the effective date of coverage; and **[**(3)**]** (C) any policy, application or sales brochure issued for such short-term health insurance policy that imposes such preexisting conditions provision shall disclose in a conspicuous manner in not less than fourteen-point bold face type the following statement:

"THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE."

(2) In the event an insurer or health care center issues two consecutive short-term health insurance policies on a nonrenewable basis for six months or less **[**which imposes**]** that impose a preexisting conditions provision to the same individual, the insurer or health care center shall reduce the preexisting conditions exclusion period in the second policy by the period of time such individual was covered under the first policy. If the same insurer or health care center issues a third or subsequent such short-term health insurance policy to the same

individual, such insurer or health care center shall reduce the preexisting conditions exclusion period in the third or subsequent policy by the cumulative time covered under the prior policies. Nothing in this section shall be construed to require such short-term health insurance policy to be issued on a guaranteed issue or guaranteed renewable basis.

[(h) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to enforce the provisions of HIPAA and this section concerning preexisting conditions and portability.**]**

Sec. 9. Subsection (a) of section 38a-478g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each managed care contract delivered, issued for delivery, renewed, amended or continued in this state shall be in writing and a copy thereof furnished to the group contract holder or individual contract holder, as appropriate. Each such contract shall contain the following provisions: (1) Name and address of the managed care organization; (2) eligibility requirements; (3) a statement of copayments, deductibles or other out-of-pocket expenses the enrollee must pay; (4) a statement of the nature of the health care services, benefits or coverages to be furnished and the period during which they will be furnished and, if there are any services, benefits or coverages to be excepted, a detailed statement of such exceptions; (5) a statement of terms and conditions upon which the contract may be cancelled or otherwise terminated at the option of either party; (6) claims procedures; (7) enrollee grievance procedures; (8) continuation of coverage; (9) **[**conversion; (10)**]** extension of benefits, if any; **[**(11)**]** (10) subrogation, if any; **[**(12)**]** (11) description of the service area, and out-of-area benefits and services, if any; **[**(13)**]** (12) a statement of the amount the enrollee or others on his behalf must pay to the managed care organization and the manner in which such amount is payable; **[**(14)**]** (13) a statement that the contract includes the endorsement

thereon and attached papers, if any, and contains the entire contract; **[**(15)**]** (14) a statement that no statement by the enrollee in his application for a contract shall void the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract; and **[**(16)**]** (15) a statement of the grace period for making any payment due under the contract, which shall not be less than ten days. The commissioner may waive the requirements of this subsection for any managed care organization subject to the provisions of section 38a-182.

Sec. 10. Section 38a-505 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

In order to provide reasonable simplification of terms and coverages of individual health insurance policies, to facilitate public understanding and comparison, to eliminate provisions **[**which**]** that may be misleading or unreasonably confusing in connection with either the purchase of such coverage or with the settlement of claims and to provide for full disclosure in the sale of such coverages:

[(a)**]** (1) The commissioner shall **[**issue**]** adopt regulations, in accordance with the provisions of chapter 54, to establish specific standards for policy provisions used in individual health insurance policies, **[**but not including group conversion policies, which**]** that shall be in addition to and in accordance with sections 38a-80, 38a-321 to 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, and other applicable laws of this state **[**which**]** that may cover the terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacements, recurrent conditions, preexisting conditions, and the definition of the

terms hospital, accident, sickness, injury, physician, accidental means, total disability, permanent disability, partial disability, nervous disorders, guaranteed renewable **[**,**]** and noncancellable.

[(b)**]** (2) The commissioner shall adopt regulations, in accordance with chapter 54, that specify prohibited policy provisions not otherwise specifically authorized by statute **[**which**]** that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, any person insured under the policy **[**,**]** or any beneficiary.

[(c)**]** (3) The commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits under each of the following categories of coverage in individual policies: **[**, other than conversion policies issued pursuant to a contractual conversion privilege under a group policy:**]** Basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage and specified disease coverage.

[(d)**]** (4) Nothing in this section shall preclude the issuance of any policy **[**which**]** that combines two or more of the categories of coverage enumerated in **[**subsection (c)**]** subdivision (3) of this section, except that specified accident coverage shall not be combined with any other category of coverage. The commissioner shall prescribe the method of identification of policies based upon coverage provided.

[(e)**]** (5) No policy shall be delivered or issued for delivery in this state **[**which**]** that does not meet the prescribed minimum standards for the categories of coverage listed in **[**subsection (c)**]** subdivision (3) of this section, provided nothing in this section shall preclude the issuance or delivery of any policy **[**which**]** that does not meet such prescribed minimum standards of coverage so long as such policy is clearly identified as not meeting such prescribed standards.

[(f)**]** (6) No such policy shall be delivered in this state unless: **[**(1)**]** (A) An outline of coverage described herein accompanies the policy or **[**(2)**]** (B) the outline of coverage described in this section is delivered to the applicant at the time application is made and acknowledgment of receipt of certificate of delivery of such outline is provided the carrier with the application. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy shall accompany the policy when it is delivered. The outline of coverage shall include: **[**(A)**]** (i) A statement identifying the applicable category or categories of coverage provided by the policy in accordance with this section; **[**(B)**]** (ii) a description of the principal benefits and coverage provided in the policy; **[**(C)**]** (iii) a statement of the exceptions, reductions and limitations contained in the policy or contract; **[**(D)**]** (iv) a statement of the renewal provisions including any reservation by the carrier of a right to change premiums; and **[**(E)**]** (v) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

[(g) Notwithstanding the provisions of sections 38a-80, 38a-321 to 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, if a carrier elects to use a simplified application form, with or without any questions as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy shall cover loss developing after twelve months from any preexisting condition not specifically excluded from coverage by the terms of the policy and, except as so provided, the policy shall not include wording that would permit a defense based upon preexisting conditions.**]**

[(h)**]** (7) Regulations promulgated pursuant to this section shall specify an effective date applicable to policy and benefit riders

delivered or issued for delivery in this state on and after such effective date **[**which**]** that shall not be less than one hundred eighty days after the date of adoption or promulgation.

Sec. 11. Section 38a-512a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) Each insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity delivering, issuing for delivery, renewing, amending or continuing a group health insurance policy in this state that provides coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469 shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for other group insurance, except as provided in subparagraphs (C) and (D) of this subdivision:

(A) Upon layoff, reduction of hours, leave of absence or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for a period of thirty months after the date of such layoff, reduction of hours, leave of absence or termination of employment, except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act;

(B) Upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time;

(C) Regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence;

(D) Regardless of an individual's eligibility for other group insurance, upon termination of the group policy, coverage for covered individuals who were totally disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which such policy was terminated, provided claim is submitted for coverage within one year of the termination of such policy;

(E) The coverage of any covered individual shall terminate: (i) As to a child, (I) as set forth in section 38a-512b. If on the date specified for termination of coverage on a child, the child is incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by such insurer, center, corporation, society or other entity within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. Such insurer, center, corporation, society or other entity may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (II) for the periods set forth for such child under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time; (ii) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for

such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time; and (iii) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act;

(F) As to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time, continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the applicable premium as specified for such event in 29 USC 1162, as amended from time to time.

(2) Any continuation of coverage required by this subsection except subparagraph (D) or (F) of subdivision (1) of this subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subparagraph (A), (B) or (E) of subdivision (1) of this subsection. The employer shall not be legally obligated by section 38a-505, as amended by this act, or 38a-546 to pay such premium if not paid timely by the employee.

[(b) The plan shall make available to Connecticut residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group policy. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual health insurance policy.**]**

[(c)**]** (b) Nothing in this section shall alter or impair existing group policies **[**which**]** that have been established pursuant to an agreement **[**which**]** that resulted from collective bargaining, and the provisions required by this section shall become effective upon the next regular renewal and completion of such collective bargaining agreement.

Sec. 12. Section 38a-537 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any individual, partnership, corporation, or unincorporated association providing group health insurance coverage for its employees shall furnish each insured employee, upon cancellation or discontinuation of such health insurance, notice of the cancellation or discontinuation of such insurance. The notice shall be mailed or delivered to the insured employee not less than fifteen days next preceding the effective date of cancellation or discontinuation. Any individual or any such entity that fails to provide timely notice shall be fined not more than two thousand dollars for each violation. The Labor Commissioner shall have the authority to assess all such fines. This section shall apply to any such individual, partnership, corporation or unincorporated association that substitutes one policy providing group health insurance coverage for another such policy with no interruption in coverage.

(b) If any individual or any such entity fails to furnish notice pursuant to subsection (a) of this section, the individual or entity shall be liable for benefits to the same extent as the insurer, hospital or medical service corporation or health care center would have been liable if coverage had not been cancelled or discontinued.

(c) Any individual, partnership, corporation, or unincorporated association which makes deductions from an employee's wages for group health insurance coverage and fails to procure such coverage shall be liable for benefits to the same extent as the insurer, hospital or medical service corporation or health care center would have been

liable if coverage had been procured. If any corporation makes deductions from an employee's wages for group health insurance coverage and fails to procure such coverage, any officer of the corporation responsible for procuring such coverage for employees who wilfully failed to procure such coverage shall be personally liable for benefits to the same extent as the insurer, hospital or medical service corporation or health care center would have been liable if coverage had been procured, provided that personal liability shall only be imposed against the officer in the event that an amount owed an employee due to the officer's failure cannot otherwise be collected from the corporation itself.

[(d) Whenever an employer ceases doing business, any terminated employee whose group health insurance was discontinued on or before the date of termination of employment and who did not receive notice of such discontinuation pursuant to subsection (a) of this section shall be eligible for ninety days from the date of discontinuation to purchase as a conversion privilege an individual comprehensive health care plan for himself and any dependents covered by the discontinued group health insurance plan from the former insurer, hospital or medical service corporation, health care center or the Health Reinsurance Association, if any insurer is not issuing such coverage, with coverage retroactive to the date of discontinuation. The employee shall pay the premiums for the period of retroactive coverage. No retroactive coverage may be purchased for a period during which the employee is eligible for benefits under another group plan.**]**

Sec. 13. Section 38a-551 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

For the purposes of this section and sections 38a-552, as amended by this act, and 38a-556 to 38a-559, inclusive, as amended by this act, the following terms **[**shall**]** have the following meanings:

[(a)**]** (1) "Health insurance" or "health care plan" means hospital and

medical expenses incurred policies written on a direct basis, nonprofit service plan contracts, health care center contracts and self-insured or self-funded employee health benefit plans. **[**For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "health insurance"**]** "Health insurance" or "health care plan" does not include **[**(1)**]** (A) accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or **[**(2)**]** (B) policies of specified disease or limited benefit health insurance, provided: **[**(A)**]** (i) The carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: **[**(i)**]** (I) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; and **[**(ii)**]** (II) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policy in the state; and **[**(B)**]** (ii) for each such policy that is offered for the first time in this state on or after July 1, 2005, the carrier files with the commissioner the information and statement required in subparagraph **[**(A)**]** (B)(i) of this subdivision at least thirty days prior to the date such policy is issued or delivered in this state.

[(b)**]** (2) "Carrier" means an insurer, health care center, hospital service corporation or medical service corporation or fraternal benefit society.

[(c)**]** (3) "Insurer" means an insurance company licensed to transact accident and health insurance business in this state.

[(d)**]** (4) "Health care center" **[**means a health care center, as defined**]** has the same meaning as provided in section 38a-175.

[(e)**]** (5) "Self-insurer" or "self-insured or self-funded employee health benefit plan" means an employer or an employee welfare benefit fund or plan **[**which**]** that provides payment for or reimbursement of the whole or any part of the cost of covered hospital or medical expenses for covered individuals. **[**For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "self-insurer" shall**]** "Self-insurer" or "self-insured or self-funded employee health benefit plan" does not include any such employee welfare benefit fund or plan established prior to April 1, 1976, by any organization **[**which**]** that is exempt from federal income taxes under the provisions of Section 501 of the United States Internal Revenue Code and amendments thereto and legal interpretations thereof, except any such organization described in Subsection (c)(15) of said Section 501.

[(f)**]** (6) "Commissioner" means the Insurance Commissioner. **[**of the state of Connecticut.**]**

[(g) "Physician" means a doctor of medicine, chiropractic, naturopathy, podiatry, a qualified psychologist and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry and, subject to the provisions of section 20-138d, optometrists duly licensed under the provisions of chapter 380.

(h) "Qualified psychologist" means a person who is duly licensed or certified as a clinical psychologist and has a doctoral degree in and at least two years of supervised experience in clinical psychology in a licensed hospital or mental health center.

(i) "Skilled nursing facility" has the same meaning as "skilled nursing facility", as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(j) "Hospital" has the same meaning as "hospital", as defined in

Section 1395x, Chapter 7 of Title 42, United States Code.

(k) "Home health agency" has the same meaning as "home health agency", as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(l) "Copayment" means the portion of a charge that is covered by a plan and not payable by the plan and which is thus the obligation of the covered individual to pay.**]**

[(m)**]** (7) "Resident employer" means any person, partnership, association, trust, estate, limited liability company, corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy or receiver or trustee, thereof, or the legal representative of a deceased person, including the state of Connecticut and each municipality therein **[**, which**]** that has in its employ one or more individuals during any calendar year, commencing January 1, 1976. **[**For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, the term "resident employer" shall refer**]** "Resident employer" refers only to an employer with a majority of employees employed within the state of Connecticut.

[(n) "Eligible employee" means, with respect to any employer, an employee who either is considered a full-time employee, or who is expected to work at least twenty hours a week for at least twenty-six weeks during the next twelve months or who has actually worked at least twenty hours a week for at least twenty-six weeks in any continuous twelve-month period.

(o) "Alcoholism treatment facility" has the same meaning as provided in section 38a-533.

(p) "Totally disabled" means with respect to an employee, the inability of the employee because of an injury or disease to perform the duties of any occupation for which he is suited by reason of education, training or experience, and, with respect to a dependent, the inability

of the dependent because of an injury or disease to engage in substantially all of the normal activities of persons of like age and sex in good health.

(q) "Deductible" means the amount of covered expenses that must be accumulated during each calendar year before benefits become payable as additional covered expenses incurred.

(r) For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "disease or injury" shall include pregnancy and resulting childbirth or miscarriage.

(s) "Complications of pregnancy" means (1) conditions requiring hospital stays, when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) nonelective caesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.**]**

[(t)**]** (8) "Resident" means **[**(1) a person**]** an individual who maintains a residence in this state for a period of at least one hundred eighty days. **[**, or (2) a HIPAA or health care tax credit eligible individual who maintains a residence in this state.**]**

[(u) "HIPAA eligible individual" means an eligible individual as defined in subsection (b) of section 2741 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA).

(v) "Health care tax credit eligible individual" means a person who is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986 in accordance with the Pension Benefit Guaranty Corporation and Trade Adjustment Assistance programs of the Trade Act of 2002 (P.L. 107-210).**]**

(9) "Special health care plan" means a health insurance plan issued by the Health Reinsurance Association established under section 38a-556, as amended by this act, for low-income individuals.

(10) "Low-income individual" means an individual whose family income is less than three hundred per cent of the federal poverty level for the calendar year prior to the date of application for an individual special health care plan or the year prior to the anniversary of the effective date of such plan, as certified by such individual.

(11) "Reimbursement rate" means, with respect to an individual special health care plan, (A) seventy-five per cent of the reimbursement rate payable under Medicare for benefits normally reimbursable under Medicare, or (B) for services and supplies that are not reimbursed by Medicare, seventy-five per cent of the amount that would be payable under Medicare if Medicare was responsible for payment for such services or supplies, as estimated by the board of directors of the Health Reinsurance Association and approved by the commissioner.

Sec. 14. Section 38a-552 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[(a) (1) Every carrier offering individual health insurance in this state shall, as a condition of transacting such health insurance, make an individual comprehensive health care plan, described in section 38a-555, available to every resident of this state except residents who are both sixty-five years of age or older and eligible for Medicare. Individual comprehensive health care plans may be made available through participation in the Health Reinsurance Association in

accordance with section 38a-556, or a residual market association, in accordance with section 38a-557. The premium charged for such a plan which is not insured by or through the Health Reinsurance Association or any other residual market association may not exceed the premium which would be applicable through participation in such associations. The premium charged for such a plan insured by or through the Health Reinsurance Association shall be precisely the premium established for that particular classification under the Health Reinsurance Association. (2) Every self-insurer whose plan covers three or more employees shall make an individual comprehensive health care plan, described in section 38a-555, available under a conversion privilege to every person covered by the plan who is a resident of this state, who is not eligible for Medicare and whose coverage under the self-insured plan ceases as a result of layoff, death or termination of employment. The individual comprehensive health care plans may be provided through a carrier or through participation in the Health Reinsurance Association in accordance with section 38a-556. The premium charged for such a plan which is not insured by or through the Health Reinsurance Association may not exceed the premium established for that particular classification under the Health Reinsurance Association. The premium charged for such a plan which is insured by or through the Health Reinsurance Association shall be precisely the premium established for that particular classification under the Health Reinsurance Association.

(b) Every carrier offering group health insurance in this state shall, as a condition of transacting such health insurance, make a group comprehensive health care plan, as described in section 38a-554, available to every resident employer who is not a small employer as defined in subdivision (4) of section 38a-564.

(c) Except as provided in subdivision (c) of section 38a-505, nothing in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, shall preclude the right of carriers to transact other kinds of insurance for which they are authorized, nor preclude the right of carriers to transact

any other lawful kind of health insurance.

(d) Nothing in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, shall require a carrier to make available coverage under a group or individual comprehensive health care plan to any person or group who is already covered under such a plan.**]**

No individual or organization that provides medical advice, diagnosis, care or treatment of a type covered under a special health care plan shall provide such service to any person in this state unless such individual or organization provides such service, upon request, on the basis of the applicable reimbursement rate, to low-income individuals or their dependents covered under such special health care plans.

Sec. 15. Section 38a-556 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is hereby created a nonprofit legal entity to be known as the Health Reinsurance Association. All insurers, health care centers and self-insurers doing business in the state, as a condition to their authority to transact the applicable kinds of health insurance defined in section 38a-551, as amended by this act, shall be members of the association. The association shall perform its functions under a plan of operation established and approved under subsection **[**(a)**]** (b) of this section, and shall exercise its powers through a board of directors established under this section.

[(a)**]** (b) (1) The board of directors of the association shall be made up of nine individuals selected by participating members, subject to approval by the commissioner, two of whom shall be appointed by the commissioner on or before July 1, 1993, to represent health care centers. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be

entitled to vote in person or proxy. The vote shall be a weighted vote based upon the net health insurance premium derived from this state in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

(2) The board shall submit to the commissioner a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner. **[**consistent with the date on which the coverage under sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, must be made available. The commissioner shall, after notice and hearing, approve the plan of operation provided such plan is determined to be suitable to assure the fair, reasonable and equitable administration of the association, and provides for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or if at any time thereafter the board fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules**]** Such plan shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall: **[**, in addition to requirements enumerated in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive:**]** (A) Establish procedures for the handling and accounting of assets and moneys of the association; (B) establish regular times and places for meetings of the board of directors; (C) establish procedures for records

to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner; (D) establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner; (E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations; (F) establish procedures for the selection of an administrator and set forth the powers and duties of the administrator; (G) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and (H) **[**establish procedures for the advertisement on behalf of all participating carriers of the general availability of the comprehensive coverage under sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional provisions necessary for the association to qualify as an acceptable alternative mechanism in accordance with Section 2744 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191; and (J)**]** contain additional provisions necessary for the association to establish health insurance plans that qualify as acceptable coverage in accordance with the Pension Benefit Guaranty Corporation and **[**Trade Adjustment Assistance programs of the Trade Act of 2002, P.L. 107-210. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish criteria for the association to qualify as an acceptable alternative mechanism**]** other state or federal programs that may be established.

[(b)**]** (c) The association shall have the general powers and authority granted under the laws of this state to carriers to transact the kinds of insurance defined under section 38a-551, as amended by this act, and in addition thereto, the specific authority to: (1) Enter into contracts necessary or proper to carry out the provisions and purposes of this section and sections **[**38a-505, 38a-546 and**]** 38a-551, as amended by this act, and 38a-556a to 38a-559, inclusive; (2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating members; (3)

take such legal action as necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association; (4) establish, with respect to health insurance provided by or on behalf of the association, appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the operational expenses of the association; (5) administer any type of reinsurance program, for or on behalf of participating members; (6) pool risks among participating members; (7) issue policies of insurance **[**on an indemnity or provision of service basis providing the coverage**]** required or permitted by this section and sections **[**38a-505, 38a-546 and**]** 38a-551, as amended by this act, and 38a-556a to 38a-559, inclusive, in its own name or on behalf of participating members; (8) administer separate pools, separate accounts or other plans as deemed appropriate for separate members or groups of members; (9) operate and administer any combination of plans, pools, reinsurance arrangements or other mechanisms as deemed appropriate to best accomplish the fair and equitable operation of the association; (10) set limits on the amounts of reinsurance that may be ceded to the association by its members; (11) appoint from among participating members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association; **[**and**]** (12) apply for and accept grants, gifts and bequests of funds from other states, federal and interstate agencies and independent authorities, private firms, individuals and foundations for the purpose of carrying out its responsibilities. Any such funds received shall be deposited in the General Fund and shall be credited to a separate nonlapsing account within the General Fund for the Health Reinsurance Association and may be used by the Health Reinsurance Association in the performance of its duties; and (13) perform such other duties and responsibilities as may be required by state or federal law or permitted by state or federal law and approved by the commissioner.

[(c) Every member shall participate in the association in accordance with the provisions of this subsection. (1) A participating member shall determine the particular risks it elects to have written by or through the association. A member shall designate which of the following classes of risks it shall underwrite in the state, from which classes of risk it may elect to reinsure selected risks: (A) Individual, excluding group conversion; and (B) individual, including group conversion. (2) No member shall be permitted to select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks that are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the participating member except in accordance with the rules established by the association. (3)**]**

(d) Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. **[**Separate scales of premium rates based on age shall apply, but rates shall not be adjusted for area variations in provider costs. Premium rates shall take into consideration the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by insurers for groups of ten lives, provided incurred losses that result from provision of coverage in accordance with section 38a-537 shall not be considered. In no event shall the rate for a given classification or group be less than one hundred twenty-five per cent or more than one hundred fifty per cent of the average rate charged for that classification with similar characteristics under a policy covering ten lives.**]** All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries, shall be filed with the commissioner and may be disapproved within sixty days **[**from**]** after the filing thereof if excessive, inadequate or unfairly discriminatory.

[(d)**]** (e) (1) Following the close of each fiscal year, the administrator shall determine the net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. Any net loss shall be assessed to all participating members in proportion to their respective shares of the total health insurance premiums earned in this state during the calendar year, or with paid losses in the year, coinciding with or ending during the fiscal year of the association or on any other equitable basis as may be provided in the plan of operations. For self-insured members of the association, health insurance premiums earned shall be established by dividing the amount of paid health losses for the applicable period by eighty-five per cent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

(2) Any net loss to the association represented by the excess of its actual expenses of administering policies issued by the association over the applicable expense allowance shall be separately assessed to those participating members who do not elect to administer their plans. All assessments shall be on an equitable formula established by the board.

(3) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with the commissioner for his review and the association shall be subject to the provisions of section 38a-14.

[(4) For the fiscal year ending December 31, 1993, and the first quarter of the fiscal year ending December 31, 1994, the administrator shall not include health care centers in assessing any net losses to participating members.**]**

[(e)**]** (f) All policy forms issued by or through the association shall conform in substance to prototype forms developed by the association, shall in all other respects conform to the requirements of this section and sections **[**38a-505, 38a-546 and**]** 38a-551, as amended by this act, and 38a-556a to 38a-559, inclusive, and shall be approved by the commissioner. The commissioner may disapprove any such form if it contains a provision or provisions **[**which**]** that are unfair or deceptive or **[**which**]** that encourage misrepresentation of the policy.

[(f)**]** (g) Unless otherwise permitted by the plan of operation, the association shall not issue, reissue or continue in force **[**comprehensive**]** health care plan coverage with respect to any person who is already covered under an individual or group **[**comprehensive**]** health care plan, or who is sixty-five years of age or older and eligible for Medicare or who is not a resident of this state. **[**Coverage provided to a HIPAA or health care tax credit eligible individual may be terminated to the extent permitted by HIPAA or the Trade Act of 2002, respectively.**]**

[(g)**]** (h) Benefits payable under a **[**comprehensive**]** health care plan insured by or reinsured through the association shall be paid net of all other health insurance benefits paid or payable through any other source, and net of all health insurance coverages provided by or pursuant to any other state or federal law including Title XVIII of the Social Security Act, Medicare, but excluding Medicaid.

[(h)**]** (i) There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, the Health Reinsurance Association or its agents or its employees or the residual market mechanism established under the provisions of section 38a-557, as amended by this act, or its agents or its employees, or the commissioner or **[**his**]** the commissioner's representatives for any action taken by them in the performance of their duties under this section and sections **[**38a-505, 38a-546 and**]** 38a-551, as amended by this act, and 38a-556a to 38a-559, inclusive. This

provision shall not apply to the obligations of a carrier, a self-insurer, the Health Reinsurance Association or the residual market mechanism for payment of benefits provided under a **[**comprehensive**]** health care plan.

Sec. 16. Section 38a-557 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Hospital service corporations and medical service corporations may **[**elect to meet the obligations of section 38a-552 by participating**]** participate in the Health Reinsurance Association established in section 38a-556, as amended by this act, as a full member thereof, or by making **[**comprehensive**]** health care plans available directly through a subscriber contract or combination of contracts or by forming a separate residual market mechanism substantially similar to **[**the association established in section 38a-556**]** said association.

(b) In the event that hospital service corporations and medical service corporations choose to form a separate residual market mechanism, the commissioner shall have the same regulatory powers over that residual market mechanism as the commissioner has over the Health Reinsurance Association, and such residual market mechanism shall have the same powers and duties as the association. Rating classifications under a residual market mechanism established under this section need not be the same as classifications established under the association, but any rates established by the residual market mechanism shall be approved by the commissioner. The commissioner shall **[**promulgate**]** adopt regulations, in accordance with the provisions of chapter 54, to carry out the requirements of this section.

(c) If hospital service corporations and medical service corporations do not elect to participate in the Health Reinsurance Association, such service corporations shall be required to make an individual **[**comprehensive**]** health care plan available to every resident of this state except residents who are both sixty-five years of age or older and

eligible for Medicare and whose coverage under a group or individual contract issued by such service corporations has terminated. Such coverage may be made available through a separate residual market mechanism established under this section.

Sec. 17. Section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in this section and sections **[**12-201, 12-211, 12-212a and 38a-565 to 38a-572, inclusive**]** 38a-566, as amended by this act, 38a-567, as amended by this act, 38a-569, as amended by this act, and 38a-574, as amended by this act:

(1) "Pool" means the Connecticut Small Employer Health Reinsurance Pool, established under section 38a-569, as amended by this act.

(2) "Board" means the board of directors of the pool.

[(3) "Eligible employee" means an employee who works a normal work week of twenty or more hours and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or contractor is included as an employee under a health care plan of a small employer but does not include an employee who works on a seasonal, temporary or substitute basis. "Eligible employee" shall include any employee who is not actively at work but is covered under the small employer's health insurance plan pursuant to (A) workers' compensation, (B) continuation of benefits pursuant to section 38a-554, or (C) other applicable laws.

(4) (A) "Small employer" means any person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months who, on at least fifty per cent of its working days during the preceding twelve months, employed no more than fifty eligible employees, the majority of whom were employed within the state of Connecticut.

"Small employer" includes a self-employed individual. For the purposes of determining the number of eligible employees under this subdivision: (i) Companies that are affiliated companies, as defined in section 33-840, or that are eligible to file a combined tax return for purposes of taxation under chapter 208 shall be considered one employer; (ii) employees covered through the employer by health insurance plans or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act shall not be counted; (iii) employees who are not actively at work but are covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits pursuant to section 38a-554 or other applicable laws shall not be counted; and (iv) employees who work a normal work week of less than thirty hours shall not be counted. Except as otherwise specifically provided, provisions of this section and sections 12-201, 12-211, 12-212a and 38a-565 to 38a-572, inclusive, that apply to a small employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

(B) "Small employer" does not include (i) a municipality procuring health insurance pursuant to section 5-259, (ii) a private school in this state procuring health insurance through a health insurance plan or an insurance arrangement sponsored by an association of such private schools, (iii) a nonprofit organization procuring health insurance pursuant to section 5-259, unless the Secretary of the Office of Policy and Management and the State Comptroller make a request in writing to the Insurance Commissioner that such nonprofit organization be deemed a small employer for the purposes of this chapter, (iv) an association for personal care assistants procuring health insurance pursuant to section 5-259, or (v) a community action agency procuring health insurance pursuant to section 5-259.**]**

(3) "Employee" means an individual employed by an employer. "Employee" does not include (A) an individual and such individual's

spouse with respect to an incorporated or unincorporated trade or business that is wholly owned by such individual, by such individual's spouse or by such individual and such individual's spouse, or (B) a partner in a partnership and such partner's spouse with respect to such partnership.

(4) (A) "Small employer" means an employer that, (i) prior to January 1, 2016, employed an average of at least one but not more than fifty employees on business days during the preceding calendar year and employs at least one employee on the first day of the group health insurance plan year, and (ii) on and after January 1, 2016, employed an average of at least one but not more than one hundred employees on business days during the preceding calendar year and employs at least one employee on the first day of the group health insurance plan year. "Small employer" does not include a sole proprietorship that employs only the sole proprietor or the spouse of such sole proprietor.

(B) (i) For purposes of subparagraph (A) of this subdivision, the number of employees shall be determined by adding (I) the number of full-time employees for each month who work a normal work week of thirty hours or more, and (II) the number of full-time equivalent employees, calculated for each month by dividing by one hundred twenty the aggregate number of hours worked for such month by employees who work a normal work week of less than thirty hours, and averaging such total for the calendar year.

(ii) If an employer was not in existence throughout the preceding calendar year, the number of employees shall be based on the average number of employees that such employer reasonably expects to employ in the current calendar year.

(C) All persons treated as a single employer under Section 414 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, shall be considered a single employer for purposes of this

subdivision.

(5) "Insurer" means any insurance company, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center, authorized to transact health insurance business in this state.

(6) "Insurance arrangement" means any multiple employer welfare arrangement, as defined in Section 3 of the Employee Retirement Income Security Act of 1974, as amended from time to time, except for any such arrangement that is fully insured within the meaning of Section 514(b)(6) of said act, as amended from time to time.

(7) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract. **[**and**]** "Health insurance plan" does not include (A) accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided that the carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after October 1, 1993, the carrier files with the commissioner the information and statement required in this

subparagraph at least thirty days prior to the date such policy is issued or delivered in this state.

(8) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to section 38a-569, as amended by this act.

[(9) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health insurance plan following the initial enrollment period provided under the terms of the first plan for which such employee or dependent was eligible through such small employer, provided an eligible employee or dependent shall not be considered a late enrollee if (A) the request for enrollment is made within thirty days after termination of coverage provided under another group health insurance plan and if the individual had not initially requested coverage under such plan solely because he was covered under another group health insurance plan and coverage under that plan has ceased due to termination of employment, death of a spouse, or divorce, or due to that plan's involuntary termination or cancellation by its carrier for reasons other than nonpayment of premium, or (B) the individual is employed by an employer who offers multiple health insurance plans and the individual elects a different health insurance plan during an open enrollment period, or (C) a court has ordered coverage be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within thirty days after issuance of such court order, or (D) if the request for enrollment is made within thirty days after the marriage of such employee or the birth or adoption of the first child by such employee after the later of the commencement of the employer's plan or the date the pool becomes operational, and satisfactory evidence of such marriage, birth or adoption is provided to the small employer carrier.

(10) "Department" means the Insurance Department.

(11) "Special health care plan" means a health insurance plan for

previously uninsured small employers, established by the board in accordance with section 38a-565 or by the Health Reinsurance Association in accordance with section 38a-570.

(12) "Small employer health care plan" means a health insurance plan for small employers, established by the board in accordance with section 38a-568.**]**

[(13)**]** (9) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health insurance plan covering such employee. "Dependent" **[**shall also include**]** includes any dependent **[**that**]** who is covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits pursuant to section **[**38a-554**]** 38a-512a, as amended by this act, or other applicable laws.

[(14)**]** (10) "Commissioner" means the Insurance Commissioner.

[(15)**]** (11) "Member" means each insurer and insurance arrangement participating in the pool.

[(16)**]** (12) "Small employer carrier" means any insurer or insurance arrangement **[**which**]** that offers or maintains group health insurance plans covering eligible employees of one or more small employers.

[(17) "Preexisting conditions provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinary prudent person to seek diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition.

(18) "Base premium rate" means, as to any health insurance plan or insurance arrangement covering one or more employees of a small

employer, the lowest new business premium rate charged by the insurer or insurance arrangement for the same or similar coverage which is equivalent in value under a plan or arrangement covering any small employer with similar case characteristics, other than claim experience, as determined by such insurer or insurance arrangement, except that as to any small employer carrier or insurance arrangement not issuing new health insurance plans or insurance arrangements to a small employer, "base premium rate" means the lowest rate charged a small employer for the same or similar coverage which is equivalent in value, under a plan or arrangement covering any small employer with similar case characteristics, other than claim experience, as determined by such insurer or insurance arrangement.

(19) "Low-income eligible employee" means an eligible employee of a small employer whose annualized wages from such small employer determined as of the effective date of the special health care plan or as of any anniversary of such effective date as certified to the insurer or insurance arrangement or the Health Reinsurance Association, as the case may be, by such small employer is less than three hundred per cent of the federal poverty level applicable to such person.

(20) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended from time to time.

(21) "Health Reinsurance Association" means the entity established and maintained in accordance with the provisions of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive.

(22) "Reimbursement rate" means, as to individuals covered under special health care plans or an individual special health care plan, seventy-five per cent of the Medicare reimbursement rate for benefits normally reimbursable under Medicare. For services or supplies not reimbursed by Medicare, such reimbursement shall be seventy-five per cent of the amount which would be payable under Medicare, if

Medicare was responsible for benefit payments under such plans for such services and supplies, as determined by the board and approved by the commissioner.

(23) "Individual special health care plan" means a health insurance plan for individuals, issued by the Health Reinsurance Association in accordance with section 38a-571 or issued by an insurer in accordance with section 38a-565.

(24) "Low-income individual" means an individual whose adjusted gross income (AGI) for the individual and spouse, from the most recent federal tax return filed prior to the date of application for the individual special health care plan or prior to any anniversary of the effective date of the plan, as certified by such individual, is less than three hundred per cent of the applicable federal poverty level.

(25) "Medicare reimbursement rate" means the amount which would be payable under Medicare for benefits normally reimbursed under Medicare.**]**

[(26)**]** (13) "Health care center" **[**means health care center as defined**]** has the same meaning as provided in section 38a-175.

[(27)**]** (14) "Case characteristics" means demographic or other objective characteristics of a small employer, including age **[**, sex, family composition, location, size of group, administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259 and industry classification, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer. Claim**]** and geographic location. "Case characteristics" does not include claims experience, health status **[**, and**]** or duration of coverage since issue. **[**are not case characteristics for the purpose of sections 38a-564 to 38a-572, inclusive.**]**

[(28) "Actuarial certification" means a written statement by a

member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of subdivisions (4), (6), (7) and (9) of section 38a-567 and the regulations promulgated by the commissioner pursuant to section 38a-567, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.**]**

Sec. 18. Section 38a-566 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any individual or group health insurance plan or any insurance arrangement shall be subject to the provisions of sections **[**12-201, 12-211, 12-212a and 38a-564 to 38a-572, inclusive**]** 38a-552, as amended by this act, 38a-564, as amended by this act, 38a-567, as amended by this act, and 38a-569, as amended by this act, if it provides health insurance or is an insurance arrangement covering one or more employees of a small employer and if any one of the following conditions are met:

(1) Any portion of the premium or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium; or

(2) The health insurance plan or arrangement is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of Section 162 or Section 106 of the United States Internal Revenue Code.

(b) Nothing in this section shall be construed to apply the provisions of sections 12-202 and 12-212a, as amended by this act, to health care centers.

(c) Notwithstanding the provisions of subsection (a) of this section, health insurance plans or insurance arrangements issued to or in

accordance with a trust established pursuant to collective bargaining, subject to the federal Labor Management Relations Act and which cover, in the aggregate, more than twenty-five employees of all participating employers, shall not be subject to the provisions of section 38a-567, as amended by this act, or subparagraph (A) of subdivision (2) of subsection **[**(e)**]** (c) of section 38a-569, as amended by this act. **[**and insurers or insurance arrangements issuing only such plans shall not be considered small employer carriers for purposes of sections 38a-565 and 38a-568.**]**

(d) A small employer carrier that ceases marketing to small employers **[**as provided in subsection (d) of section 38a-568**]** shall not cease enrolling new employers in a policy issued to provide coverage to the members of a trade association or to a trust on behalf of a trade association if the following conditions exist:

(1) Such trade association is a not-for-profit trade association qualified under 26 USC Section 501c(6), was not formed solely for the purpose of providing insurance and has been operating continuously for at least twenty-five years; **[**.**]**

(2) The policy issued to or on behalf of such association was in existence prior to June 1, 1990, and has annual premiums of less than twenty-five million dollars; **[**.**]**

(3) Such policy is offered on a guaranteed issue basis to all small employer members and only to members of such trade association.

[(e) Subsection (a) of this section shall not apply to an individual health insurance plan issued to a self-employed individual if the carrier discloses on the application and marketing materials, in not less than ten-point type, the following notice: "THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN."**]**

Sec. 19. Section 38a-567 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective from passage*):

Health insurance plans, associations of small employers and other insurance arrangements covering small employers and insurers and producers marketing such plans and arrangements shall be subject to the following provisions:

[(1) (A) (i) Any such insurer or producer marketing such plans or arrangements shall offer premium quotes to small employers upon request for coverage for employees who work a normal work week of thirty or more hours. Upon request by a small employer, such insurer or producer shall offer premium quotes for coverage for employees that include those who work a normal work week of at least twenty hours.

(ii) No small employer that has requested premium quotes for coverage for employees that include those who work a normal work week of less than thirty hours shall be required to accept such quotes or coverage in lieu of premium quotes or coverage for only those employees who work a normal work week of thirty or more hours.

(iii) Nothing in this subparagraph shall require a small employer that offers coverage to its employees who work a normal work week of thirty hours or more to offer coverage to its employees who work a normal work week of less than thirty hours.**]**

(1) (A) Any such plan or arrangement shall be offered on a guaranteed issue basis with respect to all eligible employees or dependents of such employees, at the option of the small employer, policyholder or contractholder, as the case may be.

(B) Any such plan or arrangement shall be renewable with respect to all eligible employees or dependents at the option of the small employer, policyholder or contractholder, as the case may be, except: (i) For nonpayment of the required premiums by the small employer, policyholder or contractholder; (ii) for fraud or misrepresentation of

the small employer, policyholder or contractholder or, with respect to coverage of individual insured, the insureds or their representatives; (iii) for noncompliance with plan or arrangement provisions; (iv) when the number of insureds covered under the plan or arrangement is less than the number of insureds or percentage of insureds required by participation requirements under the plan or arrangement; or (v) when the small employer, policyholder or contractholder is no longer actively engaged in the business in which it was engaged on the effective date of the plan or arrangement.

(C) Renewability of coverage may be effected by either continuing in effect a plan or arrangement covering a small employer or by substituting upon renewal for the prior plan or arrangement the plan or arrangement then offered by the carrier that most closely corresponds to the prior plan or arrangement and is available to other small employers. Such substitution shall only be made under conditions approved by the commissioner. A carrier may substitute a plan or arrangement as **[**stated above**]** set forth in this subparagraph only if the carrier effects the same substitution upon renewal for all small employers previously covered under the particular plan or arrangement, unless otherwise approved by the commissioner. The substitute plan or arrangement shall be subject to the rating restrictions specified in this section on the same basis as if no substitution had occurred, except for an adjustment based on coverage differences.

[(D) Notwithstanding the provisions of this subdivision, any such plan or arrangement, or any coverage provided under such plan or arrangement may be rescinded for fraud, intentional material misrepresentation or concealment by an applicant, employee, dependent or small employer.

(E) Any individual who was not a late enrollee at the time of his or her enrollment and whose coverage is subsequently rescinded shall be allowed to reenroll as of a current date in such plan or arrangement subject to any preexisting condition or other provisions applicable to

new enrollees without previous coverage. On and after the effective date of such individual's reenrollment, the small employer carrier may modify the premium rates charged to the small employer for the balance of the current rating period and for future rating periods, to the level determined by the carrier as applicable under the carrier's established rating practices had full, accurate and timely underwriting information been supplied when such individual initially enrolled in the plan. The increase in premium rates allowed by this provision for the balance of the current rating period shall not exceed twenty-five per cent of the small employer's current premium rates. Any such increase for the balance of said current rating period shall not be subject to the rate limitation specified in subdivision (6) of this section. The rate limitation specified in this section shall otherwise be fully applicable for the current and future rating periods. The modification of premium rates allowed by this subdivision shall cease to be permitted for all plans and arrangements on the first rating period commencing on or after July 1, 1995.

(2) Except in the case of a late enrollee who has failed to provide evidence of insurability satisfactory to the insurer, the plan or arrangement may not exclude any eligible employee or dependent who would otherwise be covered under such plan or arrangement on the basis of an actual or expected health condition of such person. No plan or arrangement may exclude an eligible employee or eligible dependent who, on the day prior to the initial effective date of the plan or arrangement, was covered under the small employer's prior health insurance plan or arrangement pursuant to workers' compensation, continuation of benefits pursuant to section 38a-554 or other applicable laws. The employee or dependent shall request coverage under the new plan or arrangement on a timely basis and such coverage shall terminate in accordance with the provisions of the applicable law.

(3) (A) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, the premium rates charged or offered for a rating period for all plans and arrangements may not exceed one

hundred thirty-five per cent of the base premium rate for all plans or arrangements.

(B) For rating periods commencing on or after July 1, 1994, and prior to July 1, 1995, the premium rates charged or offered for a rating period for all plans or arrangements may not exceed one hundred twenty per cent of the base premium rate for such rating period. The provisions of this subdivision shall not apply to any small employer who employs more than twenty-five eligible employees.

(4) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1995, the percentage increase in the premium rate charged to a small employer, who employs not more than twenty-five eligible employees, for a new rating period may not exceed the sum of:

(A) The percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(B) An adjustment of the small employer's premium rates for the prior rating period, and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer, such adjustment (i) not to exceed ten per cent annually for the rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, and (ii) not to exceed five per cent annually for the rating periods commencing on or after July 1, 1994, and prior to July 1, 1995; and

(C) Any adjustments due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's applicable rate manual.**]**

(D) Any such plan or arrangement shall provide special enrollment periods (i) to all eligible employees or dependents as set forth in 45 CFR 147.104, as amended from time to time, and (ii) for coverage under such plan or arrangement ordered by a court for a spouse or

minor child of an eligible employee where request for enrollment is made not later than thirty days after the issuance of such court order.

[(5) (A)**]** (2) (A) As used in this subdivision, "grandfathered plan" has the same meaning as "grandfathered health plan" as provided in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time.

(B) With respect to grandfathered plans **[**or arrangements issued on or after July 1, 1995**]** issued to small employers, the premium rates charged or offered **[**to small employers**]** shall be established on the basis of a **[**community rate**]** single pool of all grandfathered plans, adjusted to reflect one or more of the following classifications:

(i) Age, provided age brackets of less than five years shall not be utilized;

(ii) Gender;

(iii) Geographic area, provided an area smaller than a county shall not be utilized;

(iv) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall not be increased by more than five per cent per year;

(v) Group size, provided the highest rate factor associated with group size shall not vary from the lowest rate factor associated with group size by a ratio of greater than 1.25 to 1.0;

(vi) Administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259, as amended by this act, provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and

specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions;

(vii) Savings resulting from a reduction in the profit of a carrier **[**who**]** that writes small business plans or arrangements for an association group plan or a plan written pursuant to section 5-259, as amended by this act, provided any loss in overall revenue due to a reduction in profit is not shifted to other small employers; and

(viii) Family composition, provided the small employer carrier shall utilize only one or more of the following billing classifications: (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; and (VI) employee plus two or more dependents.

[(B) The small employer carrier shall quote premium rates to small employers after receipt of all demographic rating classifications of the small employer group. No small employer carrier may inquire regarding health status or claims experience of the small employer or its employees or dependents prior to the quoting of a premium rate.

(C) The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued on or after July 1, 1995. The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued prior to July 1, 1995, as of the date of the first rating period commencing on or after that date, but no later than July 1, 1996.

(6) For any small employer plan or arrangement on which the premium rates for employee and dependent coverage or both, vary among employees, such variations shall be based solely on age and other demographic factors permitted under subparagraph (A) of subdivision (5) of this section and such variations may not be based on health status, claim experience, or duration of coverage of specific

enrollees. Except as otherwise provided in subdivision (1) of this section, any adjustment in premium rates charged for a small employer plan or arrangement to reflect changes in case characteristics prior to the end of a rating period shall not include any adjustment to reflect the health status, medical history or medical underwriting classification of any new enrollee for whom coverage begins during the rating period.

(7) For rating periods commencing prior to July 1, 1995, in any case where a small employer carrier utilized industry classification as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary from the arithmetical average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average.

(8) Differences in base premium rates charged for health benefit plans by a small employer carrier shall be reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

(9) For rating periods commencing prior to July 1, 1995, in any case where an insurer issues or offers a policy or contract under which premium rates for a specific small employer are established or adjusted in part based upon the actual or expected variation in claim costs or actual or expected variation in health conditions of the employees or dependents of such small employer, the insurer shall make reasonable disclosure of such rating practices in solicitation and sales materials utilized with respect to such policy or contract.

(10) If a small employer carrier denies coverage as requested to a small employer that is self-employed, the small employer carrier shall promptly offer such small employer the opportunity to purchase a small employer health care plan. If a small employer carrier or any producer representing that carrier fails, for any reason, to offer

coverage as requested by a small employer that is self-employed, that small employer carrier shall promptly offer such small employer an opportunity to purchase a small employer health care plan.**]**

(C) (i) With respect to nongrandfathered plans issued to small employers, the premium rates charged or offered shall be established on the basis of a single pool of all nongrandfathered plans, adjusted to reflect one or more of the following classifications:

(I) Age, in accordance with a uniform age rating curve established by the commissioner;

(II) Geographic area, as defined by the commissioner.

(ii) Total premium rates for family coverage for nongrandfathered plans shall be determined by adding the premiums for each individual family member, except that with respect to family members under twenty-one years of age, the premiums for only the three oldest covered children shall be taken into account in determining the total premium rate for such family.

(iii) Premium rates for employees and dependents for nongrandfathered plans shall be calculated for each covered individual and premium rates for the small employer group shall be calculated by totaling the premiums attributable to each covered individual.

(iv) Premium rates for any given plan may vary by actuarially justified differences in plan design.

[(11)**]** (3) No small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(A) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer, except the provisions of this subparagraph shall not apply to information provided by a small

employer carrier or producer to a small employer regarding the carrier's established geographic service area or a restricted network provision of a small employer carrier; or

(B) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

[(12)**]** (4) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic area of the small employer. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a **[**special or a small employer**]** health care plan. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

[(13)**]** (5) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

[(14) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reasons for the denial.**]**

[(15)**]** (6) No small employer carrier or producer shall disclose (A) to a small employer the fact that any or all of the eligible employees of such small employer have been or will be reinsured with the pool, or (B) to any eligible employee or dependent the fact that he has been or will be reinsured with the pool.

[(16)**]** (7) If a small employer carrier enters into a contract, agreement or other arrangement with another party to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the other party shall be subject to the provisions of this section.

[(17)**]** (8) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers.

[(18) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. Each small employer carrier shall file with the commissioner annually, on or before March fifteenth, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods have been derived using recognized actuarial principles consistent with the provisions of sections 38a-564 to 38a-573, inclusive. Such certification shall be in a form and manner and shall contain such information as determined by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business. Any information and documentation described in this subdivision but not subject to the filing requirement shall be made available to the commissioner upon his request. Except in cases of violations of sections 38a-564 to 38a-573, inclusive, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(19) The commissioner may suspend all or any part of this section

relating to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(20) For rating periods commencing prior to July 1, 1995, a small employer carrier shall quote premium rates to any small employer within thirty days after receipt by the carrier of such employer's completed application.**]**

[(21)**]** (9) Any violation of subdivisions **[**(10) to (16)**]** (3) to (7), inclusive, of this section and of any regulations established under subdivision **[**(17)**]** (8) of this section shall be an unfair and prohibited practice under sections 38a-815 to 38a-830, inclusive.

[(22) (A) With respect to plans or arrangements issued pursuant to subsection (i) of section 5-259, at the option of the Comptroller, the premium rates charged or offered to small employers purchasing health insurance shall not be subject to this section, provided (i) the plan or plans offered or issued cover such small employers as a single entity and cover not less than three thousand employees on the date issued, (ii) each small employer is charged or offered the same premium rate with respect to each employee and dependent, and (iii) the plan or plans are written on a guaranteed issue basis.

(B) With respect to plans or arrangements issued by an association group plan, at the option of the administrator of the association group plan, the premium rates charged or offered to small employers purchasing health insurance shall not be subject to this section, provided (i) the plan or plans offered or issued cover such small employers as a single entity and cover not less than three thousand employees on the date issued, (ii) each small employer is charged or offered the same premium rate with respect to each employee and

dependent, and (iii) the plan or plans are written on a guaranteed issue basis. In addition, such association group (I) shall be a bona fide group as set forth in the Employee Retirement and Security Act of 1974, (II) shall not be formed for the purposes of fictitious grouping, as defined in section 38a-827, and (III) shall not issue any plan that shall cause undue disruption in the insurance marketplace, as determined by the commissioner.**]**

Sec. 20. Subparagraph (C) of subdivision (2) of section 38a-567 of the general statutes, as amended by section 19 of this act, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(C) (i) With respect to nongrandfathered plans issued to small employers, the premium rates charged or offered shall be established on the basis of a single pool of all nongrandfathered plans, adjusted to reflect one or more of the following classifications:

(I) Age, in accordance with a uniform age rating curve established by the commissioner;

(II) Geographic area, as defined by the commissioner**.**

(ii) Total premium rates for family coverage for nongrandfathered plans shall be determined by adding the premiums for each individual family member, except that with respect to family members under twenty-one years of age, the premiums for only the three oldest covered children shall be taken into account in determining the total premium rate for such family.

(iii) Premium rates for employees and dependents for nongrandfathered plans shall be calculated for each covered individual and premium rates for the small employer group shall be calculated by totaling the premiums attributable to each covered individual.

(iv) Premium rates for any given plan may vary by (I) actuarially justified differences in plan design, and (II) actuarially justified

amounts to reflect the policy's provider network and administrative expense differences that can be reasonably allocated to such policy.

Sec. 21. Section 38a-569 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) There is established a nonprofit entity to be known as the "Connecticut Small Employer Health Reinsurance Pool". All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state on and after July 1, 1990, shall be members of the pool.

(2) On or before July 15, 1990, the commissioner shall give notice to all insurers and insurance arrangements of the time and place for the initial organizational meeting, which shall take place by September 1, 1990. The members shall select the initial board, subject to approval by the commissioner. The board shall consist of at least five and not more than nine representatives of members. There shall be no more than two members of the board representing any one insurer or insurance arrangement. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be weighted based upon net health insurance premium derived from this state in the previous calendar year. To the extent possible, at least one-third of the members of the board shall be domestic insurance companies and at least two-thirds of the members of the board shall be small employer carriers. At least one member of the board shall be a health care center and at least one member shall be a small employer carrier with less than one hundred million dollars in net small employer health insurance premium in this state. The Insurance Commissioner shall be an ex-officio member of the board. The net premium amount shall be adjusted by the board periodically for health care cost inflation. In approving selection of the board, the commissioner shall assure that all members are fairly represented. The membership of all boards subsequent to the initial board shall, to the extent possible, reflect the same distribution of representation as is

described in this subdivision.

(3) If the initial board is not elected at the organizational meeting, the commissioner shall appoint the initial board within fifteen days of the organizational meeting.

(4) Within ninety days after the appointment of such initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The commissioner shall, after notice and hearing, approve the plan of operation provided he determines it to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis in accordance with the provisions of subsection (d) of this section, revision of 1958, revised to January 1, 2013. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this section shall be made available. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate a plan of operation or amendments, as appropriate. The commissioner shall amend any plan adopted by him, as necessary, at the time a plan of operation is submitted by the board and approved by the commissioner.

(5) **[**The**]** On and after the effective date of this section, the plan of operation shall establish procedures for: (A) Handling and accounting of assets and moneys of the pool, and for an annual fiscal reporting to the commissioner; (B) filling vacancies on the board, subject to the approval of the commissioner; (C) selecting an administrator and setting forth the powers and duties of the administrator; (D) reinsuring risks; **[**in accordance with the provisions of this section;**]** (E) collecting assessments from all members to provide for claims reinsured by the

pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made; and (F) any additional matters at the discretion of the board.

(6) The pool shall have the general powers and authority granted under the laws of Connecticut to insurance companies licensed to transact health insurance and, in addition thereto, the specific authority to: (A) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this section, including the authority, with the approval of the commissioner, to enter into contracts with programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions; (B) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members; (C) take such legal action as necessary to avoid the payment of improper claims against the pool; (D) define the array of health coverage products for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this section; (E) establish rules, conditions and procedures pertaining to the reinsurance of members' risks by the pool; (F) establish appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of the pool; (G) assess members in accordance with the provisions of subsection **[**(e)**]** (c) of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year; (H) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool; and (I) borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as

admitted assets.

(b) Any member whose health insurance plan is subject to section 38a-567, as amended by this act, may reinsure with the pool coverage of an eligible employee of a small employer **[**,**]** or any dependent of such an employee. **[**, except that no member may reinsure with the pool coverage of an eligible employee of a small employer, or any dependent of such an employee, whose premium rates are not subject to section 38a-567 pursuant to subdivision (22) of section 38a-567. Any reinsurance placed with the pool from the date of the establishment of the pool regarding the coverage of an eligible employee of a small employer, or any dependent of such an employee shall be provided as follows:**]**

[(1) (A) With respect to a special health care plan or a small employer health care plan, the pool shall reinsure the level of coverage provided; (B) with respect to other plans, the pool shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in a small employer health care plan or the actuarial equivalent thereof as defined and authorized by the board; and (C) in either case, no reinsurance may be provided in any calendar year for a reinsured employee or dependent until five thousand dollars in benefit payments have been made for services provided during that calendar year for that reinsured employee or dependent, which payments would have been reimbursed through said reinsurance in the absence of the annual five-thousand-dollar deductible. The amount of the deductible shall be periodically reviewed by the board and may be adjusted for appropriate factors as determined by the board;

(2) With respect to eligible employees, and their dependents, coverage may be reinsured: (A) Within such period of time after the commencement of their coverage under the plan as may be authorized by the board, or (B) commencing January 1, 1992, on the first plan anniversary after the employer's coverage has been in effect with the small employer carrier for a period of three years, and every third plan

anniversary thereafter, provided, commencing May 1, 1994, reinsurance pursuant to this subparagraph shall only be permitted with respect to eligible employees and their dependents of a small employer which has no more than two eligible employees as of the applicable anniversary;

(3) Reinsurance coverage may be terminated for each reinsured employee or dependent on any plan anniversary;

(4) Reinsurance of newborn dependents shall be allowed only if the mother of any such dependent is reinsured as of the date of birth of such child, and all newborn dependents of reinsured persons shall be automatically reinsured as of their date of birth; and

(5) Notwithstanding the provisions of subparagraph (A) of subdivision (2) of this subsection: (A) Coverage for eligible employees and their dependents provided under a group policy covering two or more small employers shall not be eligible for reinsurance when such coverage is discontinued and replaced by a group policy of another carrier covering two or more small employers, unless coverage for such eligible employees or dependents was reinsured by the prior carrier; and (B) at the time coverage is assumed for such group by a succeeding carrier, such carrier shall notify the pool of its intention to provide coverage for such group and shall identify the employees and dependents whose coverage will continue to be reinsured. The time limitations for providing such notice shall be established by the pool.

(c) Except as provided in subsection (d) of this section, premium rates charged for reinsurance by the pool shall be established at the following percentages of the rate established by the pool for that classification or group with similar characteristics and coverage:

(1) One hundred fifty per cent, with respect to all of the eligible employees, and their dependents, of a small employer, all of whose coverage is reinsured in accordance with subdivision (2) of subsection (b) of this section; and

(2) Five hundred per cent, with respect to an eligible employee or dependent who is individually reinsured in accordance with subdivision (2) of subsection (b) of this section and is not reinsured with all eligible employees of an employer and their dependents.

(d) Premium rates charged for reinsurance by the pool to a health care center which is approved by the Secretary of Health and Human Services as a health maintenance organization pursuant to 42 USC 300 et seq., and as such is subject to requirements that limit the amount of risk that may be ceded to the pool, may be modified by the board, if appropriate, to reflect the portion of risk that may be ceded to the pool.**]**

[(e)**]** (c) (1) Following the close of each fiscal year, the administrator shall determine the net premiums, the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. For purposes of this section, health insurance premiums earned by insurance arrangements shall be established by adding paid health losses and administrative expenses of the insurance arrangement. Health insurance premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. For purposes of this subsection, "net premiums" means health insurance premiums, less administrative expense allowances.

(2) Any net loss for the year shall be recouped by assessments of members.

(A) Assessments shall first be apportioned by the board among all members in proportion to their respective shares of the total health insurance premiums earned in this state from health insurance plans and insurance arrangements covering small employers during the calendar year coinciding with or ending during the fiscal year of the pool, or on any other equitable basis reflecting coverage of small

employers as may be provided in the plan of operations. An assessment shall be made pursuant to this subparagraph against a health care center, **[**which**]** that is approved by the Secretary of Health and Human Services as a health maintenance organization pursuant to 42 USC 300e et seq., subject to an assessment adjustment formula adopted by the board and approved by the commissioner for such health care centers **[**which**]** that recognizes the restrictions imposed on such health care centers by federal law. Such adjustment formula shall be adopted by the board and approved by the commissioner prior to the first anniversary of the pool's operation.

(B) If such net loss is not recouped before assessments totaling five per cent of such premiums from plans and arrangements covering small employers have been collected, additional assessments shall be apportioned by the board among all members in proportion to their respective shares of the total health insurance premiums earned in this state from other individual and group plans and arrangements, exclusive of any individual Medicare supplement policies as defined in section 38a-495 during such calendar year.

(C) Notwithstanding the provisions of this subdivision, the assessments to any one member under subparagraph (A) or (B) of this subdivision shall not exceed forty per cent of the total assessment under each subparagraph for the first fiscal year of the pool's operation and fifty per cent of the total assessment under each subparagraph for the second fiscal year. Any amounts abated pursuant to this subparagraph shall be assessed against the other members in a manner consistent with the basis for assessments set forth in this subdivision.

(3) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(4) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it. Insurance arrangements shall report to the board claims payments made and administrative expenses incurred in this state on an annual basis on a form prescribed by the commissioner.

(5) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(6) The board may defer, in whole or in part, the assessment of a health care center if, in the opinion of the board: (A) Payment of the assessment would endanger the ability of the health care center to fulfill its contractual obligations, or (B) in accordance with standards included in the plan of operation, the health care center has written, and reinsured in their entirety, a disproportionate number of special health care plans. In the event an assessment against a health care center is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this subsection. The health care center receiving such deferment shall remain liable to the pool for the amount deferred. The board may attach appropriate conditions to any such deferment.

[(f) (1) Neither the**]** (d) (1) The participation in the pool as members, the establishment of rates, forms or procedures **[**nor**]** or any other joint or collective action required by this section shall not be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members.

(2) Any person or member made a party to any action, suit or proceeding because the person or member served on the board or on a committee or was an officer or employee of the pool shall be held harmless and be indemnified by the program against all liability and costs, including the amounts of judgments, settlements, fines or

penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding. The indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, wilful misfeasance or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all members. The Insurance Commissioner may retain actuarial consultants necessary to carry out said commissioner's responsibilities pursuant to **[**sections 38a-564 to 38a-572, inclusive**]** this section, section 38a-564, as amended by this act, 38a-566, as amended by this act, or 38a-567, as amended by this act, and such expenses shall be paid by the pool established in this section.

Sec. 22. Section 38a-574 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) **[**On or before July 1, 1993, the**]** The board of directors of the Connecticut Small Employer Health Reinsurance Pool shall establish, subject to the approval of the Insurance Commissioner, a standard **[**underwriting form**]** family health statement for use by small employer carriers **[**for medical underwriting of health insurance plans and insurance arrangements covering small employers, as defined in section 38a-564. Within**]** to determine whether to cede lives to the reinsurance pool. Not later than ninety days after approval by the Insurance Commissioner of the **[**standard underwriting form**]** family health statement, the board shall require every small employer carrier, as a condition of transacting such business in this state, to use the **[**form for medical underwriting of**]** statement for such plans and arrangements.

(b) The **[**form**]** statement may be amended from time to time as the board deems necessary, subject to the approval of the Insurance Commissioner.

Sec. 23. Section 38a-543 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[No individual, partnership, corporation or unincorporated association which employs less than twenty employees and provides group hospital, surgical or medical insurance coverage for its employees may reduce the coverage provided to any employee or any employee's spouse solely because he has reached the age of sixty-five and is eligible for Medicare benefits except to the extent such coverage is provided by Medicare. The terms of any such plan provided by any such employer which employs twenty or more employees shall entitle any employee who has attained the age of sixty-five and any employee's spouse who has attained the age of sixty-five to group hospital, surgical or medical insurance coverage under the same conditions as any covered employee or spouse who is under the age of sixty-five.**]** No group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state shall include any provision that reduces payments on the basis that an individual is eligible for Medicare by reason of age, disability or end-stage renal disease, unless such individual enrolls in Medicare. If such individual enrolls in Medicare, any such reduction shall be only to the extent such coverage is provided by Medicare.

Sec. 24. Subsection (f) of section 5-248a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(f) **[**Notwithstanding the provisions of subsection (b) of section 38a-554, the**]** The state shall pay for the continuation of health insurance benefits for the employee during any leave of absence taken pursuant to this section. In order to continue any other health insurance coverages during such leave, the employee shall contribute that portion of the premium the employee would have been required to contribute had the employee remained an active employee during the leave period.

Sec. 25. Subsection (i) of section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(i) The Comptroller may provide for coverage of employees of municipalities, nonprofit corporations, community action agencies and small employers and individuals eligible for a health coverage tax credit, retired members or members of an association for personal care assistants under the plan or plans procured under subsection (a) of this section, provided: (1) Participation by each municipality, nonprofit corporation, community action agency, small employer, eligible individual, retired member or association for personal care assistants shall be on a voluntary basis; (2) where an employee organization represents employees of a municipality, nonprofit corporation, community action agency or small employer, participation in a plan or plans to be procured under subsection (a) of this section shall be by mutual agreement of the municipality, nonprofit corporation, community action agency or small employer and the employee organization only and neither party may submit the issue of participation to binding arbitration except by mutual agreement if such binding arbitration is available; (3) no group of employees shall be refused entry into the plan by reason of past or future health care costs or claim experience; (4) rates paid by the state for its employees under subsection (a) of this section are not adversely affected by this subsection; (5) administrative costs to the plan or plans provided under this subsection shall not be paid by the state; (6) participation in the plan or plans in an amount determined by the state shall be for the duration of the period of the plan or plans, or for such other period as mutually agreed by the municipality, nonprofit corporation, community action agency, small employer, retired member or association for personal care assistants and the Comptroller; and (7) nothing in this section or section 12-202a, 38a-551, as amended by this act, **[**38a-553**]** or 38a-556, as amended by this act, shall be construed as requiring a participating insurer or health care center to issue

individual policies to individuals eligible for a health coverage tax credit. The coverage provided under this section may be referred to as the "Municipal Employee Health Insurance Plan". The Comptroller may arrange and procure for the employees and eligible individuals under this subsection health benefit plans that vary from the plan or plans procured under subsection (a) of this section. Notwithstanding any provision of part V of chapter 700c, the coverage provided under this subsection may be offered on either a fully underwritten or risk-pooled basis at the discretion of the Comptroller. For the purposes of this subsection, (A) "municipality" means any town, city, borough, school district, taxing district, fire district, district department of health, probate district, housing authority, regional work force development board established under section 31-3k, regional emergency telecommunications center, tourism district established under section 32-302, flood commission or authority established by special act, regional council of governments, transit district formed under chapter 103a, or the Children's Center established by number 571 of the public acts of 1969; (B) "nonprofit corporation" means (i) a nonprofit corporation organized under 26 USC 501 that has a contract with the state or receives a portion of its funding from a municipality, the state or the federal government, or (ii) an organization that is tax exempt pursuant to 26 USC 501(c)(5); (C) "community action agency" means a community action agency, as defined in section 17b-885; (D) "small employer" means a small employer, as defined in **[**subparagraph (A) of subdivision (4) of**]** section 38a-564, as amended by this act; (E) "eligible individuals" or "individuals eligible for a health coverage tax credit" means individuals who are eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in accordance with the Pension Benefit Guaranty Corporation; **[**and Trade Adjustment Assistance programs of the Trade Act of 2002 (P.L. 107-210);**]** (F) "association for personal care assistants" means an organization composed of personal care attendants who are employed by recipients

of service (i) under the home-care program for the elderly under section 17b-342, (ii) under the personal care assistance program under section 17b-605a, (iii) in an independent living center pursuant to sections 17b-613 to 17b-615, inclusive, or (iv) under the program for individuals with acquired brain injury as described in section 17b-260a; and (G) "retired members" means individuals eligible for a retirement benefit from the Connecticut municipal employees' retirement system.

Sec. 26. Subdivision (7) of section 12-201 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(7) "Gross direct premiums" means all receipts of premiums from policyholders and applicants for policies, whether received in the form of money or other valuable consideration, but excluding annuity premiums and considerations and premiums received for reinsurances assumed from other insurance companies; **[**and premiums received after July 1, 1990, and before January 1, 1995, for any special health care plan, as defined in section 38a-564;**]**

Sec. 27. Subsection (c) of section 12-211 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The provisions of this section shall not apply to ad valorem taxes on real or personal property, personal income taxes, fees for agents' licenses, special purpose assessments imposed in connection with particular kinds of insurance including, but not limited to, workers' compensation assessments and Insurance Guaranty Association Fund assessments, or to premium taxes on special health care plans as defined in **[**section**]** sections 38a-564, revision of 1958, revised to January 1, 2013, and 38a-551, as amended by this act, except in the case where another state or foreign country imposes upon Connecticut domiciled insurers retaliatory charges for such taxes, fees or

assessments.

Sec. 28. Section 12-212a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

All corporations organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, shall pay to the Commissioner of Revenue Services on or before March first, annually, a charge at the rate of two per cent of the total net direct subscriber charges **[**, excluding those net direct subscriber charges received after July 1, 1990, and before January 1, 1995, from employers for any special health care plan, as defined in section 38a-564,**]** received by such corporation during the next preceding calendar year, which shall be in addition to any other payment required under section 38a-48. The charge required under this section and any other payment required under said section 38a-48 shall be in compensation for the costs and expenses of regulation by the Insurance Department and all other governmental services. The provisions of this chapter pertaining to the filing of returns, declarations, assessment and collection of taxes, and penalties imposed on domestic insurance companies shall apply with respect to the charge imposed under this section, provided corporations subject to the charge imposed under this section shall not be subject to any tax imposed under this chapter.

Sec. 29. Subsection (e) of section 17b-265 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) **[**Notwithstanding the provisions of subsection (c) of section 38a-553, no**]** No self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care plan, or any plan offered or administered by a health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a

health care item or service, shall contain any provision that has the effect of denying or limiting enrollment benefits or excluding coverage because services are rendered to an insured or beneficiary who is eligible for or who received medical assistance under this chapter. No insurer, as defined in section 38a-497a, shall impose requirements on the state Medicaid agency, which has been assigned the rights of an individual eligible for Medicaid and covered for health benefits from an insurer, that differ from requirements applicable to an agent or assignee of another individual so covered.

Sec. 30. Subsection (c) of section 17b-284 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The commissioner may pay under the Medicaid program, within available appropriations, the premiums for continued health insurance coverage under an employer's group health insurance plan, pursuant to section **[**38a-554**]** 38a-512a, as amended by this act, for chronically ill and disabled persons who are no longer employed and would otherwise be eligible for Medicaid.

Sec. 31. Subdivision (6) of subsection (c) of section 17b-299 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(6) Expiration of the continuation of coverage periods set forth in section **[**38a-554**]** 38a-512a, as amended by this act;

Sec. 32. Subsection (b) of section 17b-611 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The contract shall provide the same benefits as are provided under contracts issued pursuant to sections 38a-505, as amended by this act, 38a-546, 38a-551, as amended by this act, and 38a-556 to 38a-559, inclusive, as amended by this act, except mental and nervous

disorders shall be covered in accordance with section 38a-514.

Sec. 33. Subsection (b) of section 19a-7b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The commission shall develop the design, administrative, actuarial and financing details of program initiatives necessary to attain the goal described in section 19a-7a. **[**The commission shall study the experience of the state under the programs and policies developed pursuant to sections 12-201, 12-211, 12-212a, 17b-277, 17b-282 to 17b-284, inclusive, 17b-611, 19a-7a to 19a-7d, inclusive, subsection (a) of 19a-59b, subsection (b) of section 38a-552, subsection (d) of section 38a-556 and sections 38a-564 to 38a-573, inclusive, and shall make interim reports to the General Assembly on its findings by January 15, 1991, and by February 1, 1992, and a final report on such findings by February 1, 1993.**]** The commission shall make recommendations to the General Assembly on any legislation necessary to further the attainment of the goal described in section 19a-7a.

Sec. 34. Subsection (a) of section 31-51o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Whenever a relocation or closing of a covered establishment occurs, the employer of the covered establishment shall pay in full for the continuation of existing group health insurance, no matter where the group policy was written, issued or delivered, for each affected employee and his dependents, if covered under the group policy, from the date of relocation or closing for a period of one hundred twenty days or until such time as the employee becomes eligible for other group coverage, whichever is the lesser, provided any right of such employee and his dependents to a continuation of coverage, as required by section **[**38a-538 or 38a-554**]** 38a-512a, as amended by this

act, shall not be affected by the provisions of this section, and provided further the period of continued coverage required by said sections shall not commence until the period of continued coverage established by this section has terminated.

Sec. 35. Section 38a-472d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Not later than January 1, 2006, the Insurance Commissioner, in consultation with the Commissioner of Social Services and the Healthcare Advocate, shall develop a comprehensive public education outreach program to educate health insurance consumers about the availability and general eligibility requirements of various health insurance options in this state. The program shall maximize public information concerning health insurance options in this state and shall provide for the dissemination of such information on the Insurance Department's Internet web site.

(b) The information on the department's Internet web site shall reference the availability and general eligibility requirements of (1) programs administered by the Department of Social Services, including, but not limited to, the Medicaid program and the HUSKY Plan, Part A and Part B, (2) health insurance coverage provided by the Comptroller under subsection (i) of section 5-259, as amended by this act, **[**(3) health insurance coverage available under comprehensive health care plans issued pursuant to part IV of this chapter, and (4)**]** and (3) other health insurance coverage offered through local, state or federal agencies or through entities licensed in this state. The commissioner shall update the information on the web site at least quarterly.

Sec. 36. Subsection (b) of section 38a-480 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) **[**The**]** Except as otherwise provided in this title, the provisions of

sections 38a-481 to 38a-488, inclusive, as amended by this act, 38a-492, 38a-502 and 38a-505, as amended by this act, shall not apply to any subscriber contract issued by a health care center.

Sec. 37. Section 38a-573 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

If any provision of **[**sections**]** section 38a-564, as amended by this act, **[**to 38a-572, inclusive**]** 38a-566, as amended by this act, 38a-567, as amended by this act or 38a-569, as amended by this act, is held invalid, the invalidity shall not affect other provisions of said sections **[**which**]** that can be given effect without the invalid provisions.

Sec. 38. Sections 38a-538, 38a-553 to 38a-555, inclusive, 38a-565, 38a-568 and 38a-570 to 38a-572, inclusive, of the general statutes are repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-183(a)
Sec. 2	*from passage*	38a-199
Sec. 3	*from passage*	38a-208
Sec. 4	*from passage*	38a-214
Sec. 5	*from passage*	38a-218
Sec. 6	*from passage*	38a-481
Sec. 7	*from passage*	38a-513(a) and (b)
Sec. 8	*from passage*	38a-476
Sec. 9	*from passage*	38a-478g(a)
Sec. 10	*from passage*	38a-505
Sec. 11	*from passage*	38a-512a
Sec. 12	*from passage*	38a-537
Sec. 13	*from passage*	38a-551
Sec. 14	*from passage*	38a-552
Sec. 15	*from passage*	38a-556
Sec. 16	*from passage*	38a-557
Sec. 17	*from passage*	38a-564
Sec. 18	*from passage*	38a-566

Sec. 19	*from passage*	38a-567
Sec. 20	*January 1, 2016*	38a-567(2)(C)
Sec. 21	*from passage*	38a-569
Sec. 22	*from passage*	38a-574
Sec. 23	*from passage*	38a-543
Sec. 24	*from passage*	5-248a(f)
Sec. 25	*from passage*	5-259(i)
Sec. 26	*from passage*	12-201(7)
Sec. 27	*from passage*	12-211(c)
Sec. 28	*from passage*	12-212a
Sec. 29	*from passage*	17b-265(e)
Sec. 30	*from passage*	17b-284(c)
Sec. 31	*from passage*	17b-299(c)(6)
Sec. 32	*from passage*	17b-611(b)
Sec. 33	*from passage*	19a-7b(b)
Sec. 34	*from passage*	31-51o(a)
Sec. 35	*from passage*	38a-472d
Sec. 36	*from passage*	38a-480(b)
Sec. 37	*from passage*	38a-573
Sec. 38	*from passage*	Repealer section

Statement of Purpose:

To (1) update the health insurance statutes to reflect changes in federal law, (2) give the Insurance Department the authority to approve small employer group health insurance rates, and (3) specify that health insurance policies may not reduce payments on the basis that an individual is eligible for Medicare unless such individual enrolls in Medicare.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]